NC STATE UNIVERSITY

# Referring Veterinarian Nutrition Consult Request

Veterinary Hospital
Phone: 919.513.6999
Fax: 919.513.6905
Email: NCStateVeterinaryNutrition@ncsu.edu
Date: _____

| Referred for: **NUTRITIONAL CONSULTS to RDVM** | **Options available:** | **Fee** |
|---|---|---|
| ☐ Courtesy commercial diet options & Nutrition-related inquiries | | No charge |
| ☐ Assisted (tube) feeding recommendations (To referring veterinarian) | | $98 |
| **NUTRITIONAL CONSULTS TO PET OWNER** | **Options available:** | |
| **STEP 1: CHOOSE 1:** | | |
| ☐ Initiating Consult by phone | | $22/15 minutes |
| ☐ Initiating Consult by in-person visit | | $103 |
| ☐ **STEP 2: CHOOSE 1:** | | |
| ☐ Commercial Diet feeding recommendations | | $84 |
| ☐ Obesity consultation | | $107 |
| ☐ Homemade diet formulation | | $462 |
| ☐ Homemade diet and commercial diet options | | $525 |

Referred by:

_____ of _____
Name Hospital

_____
Street Address

_____
City State_____ Zip_____

_____ _____
Phone Fax

_____
Email

Patient/Client Information:

_____ DOB: _____ Age: _____
Pet Name
☐ Canine ☐ Feline
☐F ☐ F/S ☐ M ☐ M/C

_____ Body weight _____ ☐ kg ☐ lb Body Condition Score ___ / 9
Breed
Muscle Condition Score ☐normal ☐mild atrophy
☐moderate atrophy ☐severe atrophy

_____
Client Name

_____
Street Address

_____
City State Zip

_____ _____
Phone Email

*Revised 01.05.2021 JN KS*

**Summary of current and historical medical diagnoses:**
****PLEASE INCLUDE ALL PERTINENT MEDICAL RECORDS ****
Example: IRIS stage 2 CKD – proteinuric, normotensive. Stable past 6 months. Tx amlodipine and enalapril.

1. _____
2. _____
3. _____
4. _____

## PLEASE INDICATE THE SPECIFIC QUESTIONS YOU WOULD LIKE ADDRESSED IN THIS CONSULTATION REQUEST (*ESPECIALLY FOR NO-CHARGE RDVM CONSULTS)*

_____

_____

_____

_____

**Current Appetite:** ☐ **Normal** | ☐ **Decreased by** ___ **25%** ___ **50%** ___ **75%** ☐ for 1-7 days ☐ for > 7 days | ☐ **Anorexic** ☐ for 1-7 days ☐ for > 7 days

**Unintended change in body weight?** ☐ **No**
☐ **Yes – gained** ____ ☐ kgs / ☐ lbs over ___ ☐ weeks / ☐ months
☐ **Yes – lost** ____ ☐ kgs / ☐ lbs over ___ ☐ weeks / ☐ months

**History of gastrointestinal intolerance?**
Please check all that apply

☐ **No**
☐ **Yes – vomiting** for ___ ☐ weeks / ☐ months / ☐ years
☐ **Yes – regurge** for ___ ☐ weeks / ☐ months / ☐ years
☐ **Yes – diarrhea** for ___ ☐ weeks / ☐ months / ☐ years

If checked yes, please describe frequency, identifiable predisposing factors, treatments provided and response.

_____

_____

_____

_____

*Thank you for your referral. We appreciate the confidence you place in our service.*

**Please return form and pertinent medical records/ diagnostic results via:**
or Email NCStateVeterinaryNutrition@ncsu.edu **(PREFERRED)** or Fax (919.513.6905)

*Revised 03.11.2022JNKS*